EXISTING EMPLOYER
OPTION SELECTION RESOLUTION
WISCONSIN PUBLIC EMPLOYERS' GROUP HEALTH INSURANCE PROGRAM

RESOLVED, by the _____ of the _____
(Governing Body) (Employer Legal Name)

that pursuant to the provisions of Section 40.51 (7) of the Wisconsin Statutes hereby determines to offer the Group Health Insurance Program to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the program as set forth in the contract between the Group Insurance Board and the participating health insurance providers.

All participants in the WPE Group Health Insurance Program will need to be enrolled in either the Traditional HMO Option or the Deductible HMO Option. An employer may not split its group between the options.

We choose to participate in the: (check only one box)

☐ Traditional HMO Option paired with the Classic Standard Plan (**current benefit**)

☐ Traditional HMO Option paired with the Standard PPP (**new option**).

☐ Deductible HMO Option paired with the Deductible Standard Plan (**new option**)

☐ Deductible HMO Option paired with the Deductible Standard PPP (**new option**)

The resolution must be received by the Department of Employee Trust Funds no later than March 1, 2005. Coverage will be effective on the first day of the month following 90 days after the Department receives the resolution.

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Group Health Insurance.

CERTIFICATION

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the ____ day of _____, year _____ and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this ____ day of _____, year _____.

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent statements, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

_____
Employer Representative Title

_____
Employer County

_____
Mailing Address

Number of eligible employees _____

_____
ETF Employer Identification Number